Retriage in SW RTCC

Retriage criteria in LA County

- 1. Persistent signs of poor perfusion
- 2. Need for immediate blood replacement therapy
- 3. Intubation required
- 4. Glasgow Coma Score less than 9
- 5. Glasgow Coma Score deteriorating by 2 or more points during observation
- 6. Penetrating injuries to head, neck, chest or abdomen
- 7. Extremity injury with neurovascular compromise or loss of pulses
- 8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

Retriage in LA County

- B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.
- C. Contact 9-1-1 for transportation. The paramedic scope of practice does not include paralyzing agents and blood products.
- D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

MVA at low speed

- 20 y F driving and felt abdominal pain and had low speed MVA
- 11:00 EMT arrival cool, pale diaphoretic with BP 75/36
- BP increased to 89/49 with 500 cc fluid bolus
- Transported to non trauma center
- 11:47 arrived ED BP103/59, pulse 129
- 14:49 hg 8 prbc ordered, transfused uncrossmatched blood

MVA at low speed

- 15:13 CT scan splenic rupture with hemoperitoneum
- 15:15 decision to transfer
- 15:52 left for UCLA 1 unit prbc with nurse
- 16:09 arrive UCLA critical code trauma in extremis
- 16:15 prbc rapid transfuser
- 16:20 to Operating room

Doctor crashes on mountain bike

- 39 year old physician visiting LA crashes on mountain bike ride
- Walks into ED with left chest pain
- Triaged to urgent care clinic
- CXR normal discharged with Percocet
- Returns to hotel room and develops increasing abdominal pain
- Goes back to ED with severe abdominal pain

Mountain biker in ED at non trauma center

- 20:22 arrives in ED 134/94, 124 abdomen tender
- 21:17 grade 5 splenic laceration and hemoperitoneum
- 21:33 called UCLA type and screen
- 22:12 left for UCLA in ambulance, 2 units prbc en route with nurse
- 22:23 Arrive UCLA, critical code trauma, BP 80/p pulse 120
- 22:35 In OR, splenectomy

MVA T-bone

- 34 yo Female T boned high rate of speed driver side not wearing seatbelt Comorbidities Obesity BMI 42, HTN
- accident 7 mi from non- trauma center 50 mi to trauma center
- Prehospital GCS 3 90/50-160-12 assisting respirations

MVA cont.

1325: arrive community hospital

1330: 95/55 173 100% NRB GCS V1 M3 E1 2 20g IV started

1335: intubated RSI

1350: to CT bp 92/56 + spleen, skull fx SAH, pelvis fx

1440 contact trauma center for transfer

SBP 60-95 hr 150-170

Trauma center recommended to stabilize then transfer.

MVA cont.

8L NS 4uprbc

1550-1740 OR ex-lap & splenorrhaphy (3L LR, 3L NS, 7u prbc, 1 ffp, 1 plt) Aline Sc line placed SBP consistantly 80-90's then stabilized ~120 ADM ICU

Next day 0930: cc note abg improved weaned off hyperventilation – attempted to extubate-failed GCS 4 "decreased movement to one side posturing"PLAN: transfer

1345: left hospital

Lessons learned

- Its better to get them to the right place the first time
- Non trauma centers deliver non trauma center care
- It is not so easy for them to figure it out
- Once they figure it out the retriage system works
- But only if the trauma center is not far away
- The concept of transfer without work up may be a myth